		AND HUMAN SERVICES & MEDICAID SERVICES	450	7/12/15	FOR	D: 06/03/201 MAPPROVE D 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) D/	ATE SURVEY OMPLETED
		445487	B. WING		0:	5/28/2015
		FJOHNSON CITY, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604		
(X4)1D PREFIX TAG	DEFICIENCY M	MENT OF DEFICIENCIES (EACH IST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROI DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
F 157 SS=D	26-28, 2015, at Chriscity. No deficiencies complaint investigate 483.10(b)(11) NOTHE (INJURY/DECLINE/ A facility must immediace on sult with the residence of an interested family and has the positive or an interested family and has the positive of a significant of the facility of the resident involving the injury and has the positive of the facility of the facility of the facility (i.e., a new significantly (i.e., a new significantly). The facility must also and, if known, the respective of the facility must also and, if known, the respective of in §483.15(new sident rights under the facility of the facility must also and, if known, the respective of in §483.15(new sident rights under the facility of the facility of the facility must also and, if known, the respective of in §483.15(new sident rights under the facility of the	vey and complaint 9 were completed on May stian Care Center of Johnson were cited related to ion #35859. FY OF CHANGES	F 00	Preparation and/or execution of Correction does not consadmission or agreement by Chricenter of Johnson City of the tracts alleged or conclusions set the statement of deficiencies. Care Center of Johnson City file of Correction solely because it to do so for continued state lice health care provider and participation in the Medicare, program. The facility does not a any deficiency existed prior to time of, or after the survey. The reserves all rights to contest the findings through informal resolution, formal appeal and a	stitute an istian Care ruth of the set forth in Christian is this Plan is required insure as a different for for implementation of the facility he survey dispute any other inistrative correction is shing any y submits response ceed the ent is not legal or	
BORATORY D	RECTORS OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(X6) DATE

Any deficiency statement ending with an astertsk (')denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 11

MPH, NHA

Administrator

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2015 FORMAPPROVED OMB NO 0938-0391

<u> </u>	TO LOTE MEDIOMICE	A MICHIOVID SEVAICES				NIR MO	0938-0393	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445487	B. WING	;		05/	28/2015	
	NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF JOHNSON CITY, INC			STREET ADDRESS, CITY, STATE, ZIP CODE  140 TECHNOLOGY LANE  JOHNSON CITY, TN 37604				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (I CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIAT DEFICIENCY)	oss-	(X5) COMPLETION DATE	
	This REQUIREMEN by: Based on facility p review, and intervie the physician of a re and death, for one re reviewed.  The findings include Medical record reviewas re-admitted to the diagnoses including Stage IV, Extensive Hypertension, Parox Bilateral Nephrostom Wound to the Coccy Review of facility pol Documentation, date Chart all pertinent ch condition4c. Chart three [3] daysMisce should also include a family is called about responseDeath of a Documentation perta resident includes: a. death [i.e. symptoms,	or interested family member.  T is not met as evidenced olicy review, medical record w, the facility failed to notify sident's change in condition esident (#101) of 38 residents d:  W revealed Resident #101 he facility on 2/23/15 with Metastatic Prostate Cancer, Bony Metastasis, Anasarca, ymal Atrial Fibrillation, y, and a Stage III Pressure x.  Icy, Charting and revised 6/2014, revealed "1. anges in the Resident's t on all shifts for the first ellaneous; 1. Documentation any time the physician or the resident, as well as their a Resident: 1. ining to the death of a Pertinent information before vital signs, treatment, etc.]	F ·		·	facility with  ndition process, to be ing the Nursing day of s were nge in process on.  ted on fursing fy the idents' encing . This n of 4-Hour		
	notified and when no Medical record reviev Progress Notes rever Resident arrived at the	eath. c. Name of physician tified"  w of the Interdisciplinary aled "2/23/2015 4:30p [PM] ne facility fromMC [Local itretcher escorted by EMS		1	Administrative Staff. This in-service varieties on 6/26/15 by the DON and to ensure Nursing Staff is educated, thired nurses will be educated by during their orientation period regarding	will be ADON Newly- ADON		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/03/2015 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	1 7	LTIPLE CONSTRUCTION ING	(X3) DATE	E SURVEY IPLETED	1
		445487	B. WING	<b>)</b>	05/28/2015		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1	50,2010	1
ALIDIOTI	4N 04DE 05NT5D 01			140 TECHNOLOGY LANE			
CHRISTI	AN CARE CENTER OF	F JOHNSON CITY, INC		JOHNSON CITY, TN 37604			
(X4) 1D PREFIX TAG	DEFICIENCY MI	MENT OF DEFICIENCIES (EACH UST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		BE	(X5) COMPLETION DATE	
- t	[Emergency Medica & oriented x 3 [persisigns]102/93 P [pul discomfortResider [resident required the activities of daily livit activities of daily livit Continued medical resident rentry was a nur 0754 [39 hours 24 n "While CNA [Certif taken am [morning] to this writer et [and] noted Res without re [Assistant Director of aware. No obtainable [mottling] noted in faupper and lower extra Practical Nurse] #2  Further medical reconote, dated and time resident 's room with respirations. No obtainable, cool to touch. If [pronounced dead at [Registered Nurse, A Nursing]."  Telephone interview the Administrator on the conference room conference ro	I Services]. Resident is alert on, place, time]VS [vital se]78Denies pain or not requires asst x 2 for ADLS ie assistance of 2 staff for ng]"  ecord review revealed the rese's note dated 2/25/15 at ninutes and 4 shifts later] ied Nursing Assistant] was meal into room she returned we entered this room et espiration et pulseADON of Nursing] aware, Res family evital signs. Modeling cial, B/L U +LE [bilateral remities] LPN [Licensed"  rd review revealed a nurse's d 2/23/15 at 0754, "Entered [LPN #2] no visible ainable VS [vital signs]. Skin Pronounced @ 0754 7:54 AM]RN, ADON	F	residents are experiencing the process, including death.  Monitoring  Daily Nursing 24-Hour Report Sheets audited every morning by the DON a ADON to ensure the physician was nof any report of a resident's chacondition or when a resident has experiencing a will be conducted by the DON ADON for residents experiencing a win condition or have expired in the to ensure the physician was notifier results of this audit will be present DON to the monthly Quality Assiperformance improvement Committer review and recommendations until the following compliance is met consecutive months; then quarterly QAPI Committee consists of Administrator, Medical Director, Directors of Nursing, Asst. Director of Nursing, Chanager, Housekeeping Supe Medical Records Coordinator, Services Director, Activities Director, Manager, Maintenance Director and	when dying will be ind the notified in these DN and change facility d. The ted by urance ee for ne goal for 3 /. The the ctor of bietary rvisor, Social ector, ources	6-30-15	
fa fa	at 12:10 PM, in the D acility policy and exp	ector of Nursing on 5/28/15 ON's office confirmed the ectation is that a resident's time of politication, name of		Manager and MDS Coordinator.			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/03/2015 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERISUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING \_ 445487 B. WING 05/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE

CHRISTIAN CARE CENTER OF JOHNSON CITY, INC			140 TECHNOLOGY LANE		
			JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) CONFLETION DATE	
~			Corrective Actions for Targeted		
F 157	1	F 281	<u>Residents</u>		
F 281 SS≂D	the person notified should have been documented in the medical record, and there was no record of the physician being notified of a change in the resident's condition or death.  483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS		The Family Nurse Practitioner wrote an order for the cited eye drops for Resident #20 on 5/27/15. Resident #20 showed no ill effects from the eye drop administration.  Identification of Other Residents with		
i	The services provided or arranged by the facility must meet professional standards of quality.		Potential to be Affected		
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to obtain a physician's order to dispense a PRN (as needed or requested) medication for one resident (#20) of 13 residents observed during medication administration.  The findings included:  Observation on 5/27/15 at 1:15PM, in the resident's room revealed the Licensed Practical Nurse (LPN #1) removed the stock eye drops from the medication cart and administered 2 eye drops into each of the resident's eyes.  Medical record review of the Medication		Facility residents have a potential to be affected by this practice. During monthly MAR change-over on 5/31/15, all residents' MARs were checked by a Licensed Nurse to ensure there is a transcribed order for each medication given. This MAR monthly change-over was co-signed by a second nurse to ensure transcription accuracy of MAR.  LPN #1 was counseled on 5/27/15 by the DON regarding the need to have a transcribed order documented on the MAR for any medication administered to a resident.  Systematic Changes		
	Administration Record dated 5/1/15, with LPN #1, revealed no order was transcribed for the eye drops.  Interview with LPN #1, on 5/27/2015 at 1:40PM,		Mandatory in-service will be conducted for the Nursing Staff on 6/12/15 by the DON and ADON regarding the need to administer only medications with a		
	in front of the resident's room confirmed the resident had requested the eye drops, the LPN		transcribed order on the MAR to facility residents. This in-service will be repeated		

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had given them in the past, and "was sure" the resident had a PRN order for the eye drops.

Event ID:05GJ11

Facility 10: TN9011

on 6/26/15 by the DON and ADON to

ensure the Nursing Staff is educated.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445487	B.WING			05.	/28/2015	
	NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF JOHNSON CITY, INC			STREET ADDRESS, CITY, STATE, ZIP CODE  140 TECHNOLOGY LANE  JOHNSON CITY, TN 37604				
(X4) ID PREFIX TAG	DEFICIENCY MU	MENT OF DEFICIENCIES (EACH JST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	oss-	(X5) COMPLETION DATE	
F 514 SS=D	dated 5/1/2015 and revealed no order for Interview with the Fa 5/27/2015 at 3:30 Pl confirmed there was drops for Resident #483.75(1)(1) RES RECORDS-COMPL LE  The facility must main resident in accordant standards and practical accurately document systematically organ.	the facility Standing Orders the facility Standing Orders or eye drops for the resident.  Amily Nurse Practitioner on M, in the conference room or current order for the eye #20.  ETE/ACCURATE/ACCESSIB  Intain clinical records on each ce with accepted professional ces that are complete; ed; readily accessible; and ized.	F 281 Newly-hired nurses will be educated by ADON during their orientation per regarding the need to administer of medications with a transcribed order on MAR to facility residents. Consultant Pharmacist will perform Medication Administration Observation Act of nurses during their monthly compliants to ensure each medication has transcribed order present on the MAR.  Monitoring  A monthly Medication Administration Observation Audit of nurses will also		period r only on the rm a n Audit pliance has a  tration lso be and ication d onto 6 audit			
	resident's assessmer services provided; the preadmission screen and progress notes.  This REQUIREMENT by: Based on facility policeview and interview, a complete and accuracident (#101) of 38.  The findings included Medical record review.	formation to identify the resident; a record of the sident's assessments; the plan of care and rvices provided; the results of any eadmission screening conducted by the State; d progress notes.  is REQUIREMENT is not met as evidenced: assed on facilty policy review, medical record riew and interview, the facility failed to maintain complete and accurate medical record for one sident (#101) of 38 residents reviewed.		## ## CO A H H CO A H C	will be conducted during the monthly change-over and verified by two linurses. The results of these audits a presented by the DON to the monthly of Assurance Performance Improving Committee for review and recommendantil the goal of 100% compliance is meconsecutive months; then quarterly. The Committee consists of the Administ Medical Director, Director of Nursing, Dietary Malousekeeping Supervisor, Medical Recoordinator, Social Services Directivities Director, Business Office Maluman Resources Manager, Mainte Director and Rehab Manager and Coordinator.	censed will be Quality ement lations at for 3 e QAPI trator, Asst. nager, ecords rector, nager, enance	6-30-15	
	diagnoses including M	Metastatic Prostate Cancer,						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE, & MEDICAID SERVICES

PRINTED: 06/03/2015 FORM APPROVED OMB NO 0938-0391

	TO FORT MILDIONALE	WINEDIONID OF LANDED			<u>UVI DIVI</u>	<u></u>	
STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIER(CLIA IDENTIFICATION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	445487		B.WING	3	05/	/28/2015	
1	PROVIDER OR SUPPLIER IAN CARE CENTER O	F JOHNSON CITY, INC	•	STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604	, 05	20,2013	
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAC	X  (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
	Stage IV, Extensive Hypertenion, Paroxy Nephrostomies, and to the Coccyx.  Review of facility por Documentation, date "1. Chart all pertinent condition4. New A shifts for the first through 1. Documentation of the physician or fam resident, as well as Resident: 1. Docume death of a resident information before disigns, treatment, etc. Name of physician Medical record reviee Progress Notes reversident anived at Medical Center] via Emergency Medical & oriented x 3 [person signs] 102/93 P [pulsion discomfortResident required the activities of daily living Continued medical renurse's note dated "2 hours 24 minutes and [Certified Nursing Assembly 1 and	Bony Metastasis, Anasarca, mal Atrial Fibrillation, Bilateral a Stage III Pressure Wound licy, Charting and e revised 06/2014, revealed to changes in the Resident's dmission-c. Chart on all ee (3) daysMiscellaneous: nould also include any time ily is called about the their responseDeath of a entation pertaining to the includes: a. Pertinent eath (i.e. symptoms, vital a) b. date and time of death. In notified and when notified"  W of the Interdisciplinary aled, "2/23/15 4:30 p [PM] the facility fromMC [Local stretcher escorted by EMS Services]. Resident is alert in, place, time]VS [vital ite] 78Denies pain or the requires asst x 2 for ADLS assistance of 2 staff for	F 514	Corrective Actions for Targete Residents  Resident #101 no longer resides a facility.  Identification of Other Residents  Potential to be Affected  Facility residents have the potential affected by this practice. After revithe 24-Hour Nursing Shift Report an Nursing Rounds observations on 5/ (last day of Annual Survey), no residents were identified as experienchange in condition that would readditional documentation and notification family and physician.  Systematic Changes  Mandatory in-service will be conducted 6/12/15 by the DON and ADON for Nu Staff addressing the facility Charting Documentation Policy. This incomplete following facility policy for routine chat the need to document in the merecord any pertinent changes in residucntion, and times of notification family and physician. This in-service we repeated on 6/26/15 by the DON ADON to ensure Nursing Staff is educated.	with  to be ewing d per 28/15 other cing a equire ations  ed on ursing and ludes rting, edical lents' as of ill be and		

FORM CM\$-2567(02 99) Previous Versions Obsolete

Event 1D:05GJ11

Facility 10:TN9011

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2015 FORM APPROVED OMB\_NO\_0938-0391

CENTER	3 FOR MEDICARE	A MEDICAID SERVICES		<u>C</u>	<u>MB NO</u>	<u> 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISUPPL(ERICLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	<del></del>	445487	B. WING		05/	28/2015
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ON IDIOTI	ALL 0400 0000000		1	140 TECHNOLOGY LANE		
CHRISTI	AN CARE CENTER O	F JOHNSON CITY, INC	l	JOHNSON CITY, TN 37604		
			i_			
(X4)1D		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION DATE
	ALGOLATORI OR E	BE IDENTIFFING INFORMATION)	TAG	DEFICIENCY)	KIRIE	{
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	<b>.</b>			Name to blood or over 1911	1	1 l
F 514	Continued From page	ge 6	F 51		•	i i
	in facial, B/L U +LE	[bilateral upper and lower		ADON during their orientation		
	extremities]LPN#			addressing the facility Charting	g and	
		-		Documentation Policy; which is		
	Further medical rec	ord review revealed a nurse's		following facility policy for routine cl		
		ed 2/23/2015 at 0754 (7:54		the need to document in the medical	-	i I
	AM) "Entered Book	dent 's room with [LPN #2] no			•	
\$				any pertinent changes in res		
		No obtainable VS [vital		condition, and times of notificati	ons of	
	ozea termene e e	ol to touch. Pronounced @		family and physician.		l <b>i</b>
	10 anistered Name	lead at 7:54 AM]RN, ADON		Monitoring		
Ī	[Registered Nurse, /	Assistant Director of				
l	Nursing]."			A monthly audit to ensure the	facility	
Į,	Andrew American Street			Charting and Documentation Policy i	s being	
		dministrator and LPN #2 on in the conference room		followed will be conducted by the		
	confirmed LPN #2 w	orked day shift 2/24/15 and		Coordinator. This audit will	nclude	
1	2/25/15, but the doct	for saw the resident on		following facility policy for routine ch	arting,	
	2/24/15, had the cha	art most of the day, and they		the need to document in the medical	record	
	didn't get a chance	to chart. LPN #2 also stated		any pertinent changes in res	idents'	
		the resident at 6:00 AM on		condition, and times of notification		
ĺ	5/25/15 but later in the	he interview said, "The lab		family and physician. The results		
	tech came to do a la	b draw and came out of the		I .		
]	room around /:55Al	M and said he/she thought		audit will be presented by the	MDS	
ŀ	the resident had pas	sed away."		Coordinator to the monthly	Quality	į
	Mindian) was not not be			Assurance Performance Improv	ement	l
	iviedical record revie	w of the Medical History and		Committee for review		f
	rnysical Examination	dated 2/24/15, revealed			and	1
ľ	rnysicai Exam: A	lert and Oriented checked,		recommendations until the goal of	100%	
		added comment "x 2," No		compliance is met for 3 conse	cutive	1
		ed, "fair" judgment and		months; then quarterly. The	QAPI	[
i	insight checked"			Committee consists of the Adminis	· I	1
1.	Talambana			1	- 1	
	reiepnone interview v	with the Physician, contacted		Medical Director, Director of Nursing		
		on 5/28/15 at 10:00 AM,		Director of Nursing, Dietary Ma	nager,	!
		ian remembered the		Housekeeping Supervisor, Medical R	ecords	1
		emember the circumstances		1	rector,	f
		without having the chart in		1		l
[1	front of me."	· ·		Activities Director, Business Office Ma	nager,	6-30-15
],	Intensions with the Di-	notes of Nursing (DON)		Human Resources		l
1 1	interview with the Dir	ector of Nursing (DON) on		1	J	

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Event ID:05GJ11

Fecility ID: TN9011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445487	B. WING	B. WING			/28/2015	
	NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF JOHNSON CITY, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604				
(X4)1D PREFIX TAG	FIX DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION OF PREFIX CORRECTIVE ACTION SHOULD BE OF REFERENCED TO THE APPROPRIATION OF THE A		oss-	COMPLETION DATE	
F 514	confirmed the facility in the resident's con	I. in the DON's office y failed to document changes ndition, times of notifications lysician, and the medical	F 5	514	Manager, Maintenance Director and Re Manager and MDS Coordinator,	hab		